Current Sectors of Health Care Delivery

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Upon examination specifically of the sector of Hospitals and Health Systems, cost has prevailed as the dominant factor influencing change and all other factors, including quality and access to health care. Of the various changes that have occurred in the American health care sectors, reorganization of hospitals, advances in technology, rising health insurance costs, rising pharmaceutical costs, increasing government regulation of federal funding for Medicare/Medicaid, and the consumer's expectations of health care services have all emerged as prominent issues, to name a few. No one issue appeared overnight and no perfect solution to rising costs has presented itself, rather an evolution of solutions has been offered to address rising costs and meet the balance of good health care for the money paid.

Why Cost Is Important for Hospitals and Health Systems

The movie JOHN Q is a captivating example (perhaps in the extreme) of the results of our health care system--those without adequate insurance, lack of personal wealth, and/or a Health Systems affiliation may be restricted in the level of care they receive. How did we get to this point?

In the late 1800s mostly apprenticed providers, who were paid on a fee-for-service basis, provided patient health care. This occurred despite the fact that, by this time in America, there were over sixty companies that provided health insurance. Why weren't more people using health insurance? Possibly because health care didn't cost much. The main health concerns were for acute infections or epidemics for which only basic treatments were effective. Also, providers accepted payment in kind, sometimes bartering with livestock or food.

After the 1910 Flexner Report physicians were required to pay for higher education at universities with hospital affiliations, and states began giving licenses (for a fee to providers), which authorized them to practice in their state. Also, hospitals began to be places where people went to be helped instead of places where people went to die. As the science of medicine grew, patients benefited, but the costs rose; providers needed to recover the cost of their training.

Between World Wars I and II, prepaid health care became more common with the development of Blue Cross and Kaiser, setting the stage for the largest contribution to rising health care costs of the future: capitalization. The Social Security Act (1935) insured children and the disabled. At the end of World War II (WWII) America was generating more than half of the world's gross national product (GNP); across the board wages and profits were high, and the unions pushed for and got universal health care coverage. This set the standard for nearly all employers and heightened expectations of all wage earners. Also following WW II the Hill-Burton act provided money to build more hospitals. Medical knowledge exploded and research further integrated into the medical field. Specialists instead of generalists became mainstream. People started living longer; chronic (rather than acute) disease became the main heath care issue.

In the 1950's expansion of health care resulted in patients coming to doctors with fewer doctors making house calls. The increase in patient volume in the 1960's drove the need to improve diagnostics and treatment regimes. The prevailing social attitude of universal health coverage as a universal standard also contributed to reinforcement of third party payers. With the establishment of Medicare and Medicaid (1965) the demand for hospital services grew at an unprecedented rate. Plus since Medicare and Medicaid was a federal program, the federal government could (and did) impose certain regulations and guidelines governing care, for example, good laboratory practices (GLP) were mandated to ensure precision and accuracy in lab testing.

Medicare was a nice idea, but ultimately the government could not afford to keep its promise to provide full major medical coverage to the intended population (elderly, children, infirm), which was growing. The government began to legislate their costs and level of care, passing the balance due onto the hospitals. More and more insurance companies became more selective in what they covered, putting the onus on the patient with higher co-payments for reduced services. Rising expectations of medical care/coverage, due to 1) social expectations driven by media and popular culture and 2) political promises, have outstripped the budgeting for traditional care. People expect the best, expect someone else to pay, and if patients have to pay *some*thing, they still want what they think they're paying for.

Several factors recently have caused hospital costs to climb at more than twice the inflation rate, thus promoting the moratoriums in insurance coverage. One is the cost of new equipment needed for organ transplants, renal dialysis, cancer radiation therapy, and many other rapidly changing treatments. Adding to the expense are modern diagnostic equipment, imaging technology, and the burgeoning numbers of tests that physicians are now requiring for a complete diagnosis. Research and development of new technology has added more to the equipment cost. The cost of pharmaceuticals (and the research behind that industry) has made another large dent in the expense column of every hospital budget. The greatest expense, however, is the huge staff needed to operate a hospital, which accounts for 70 percent of the costs.

Changes to the Hospital/Health Systems Sector That Have Occurred as a Result of Cost

One of the biggest impacts that cost has had on the hospital sector is through the changes in coverage provided by Medicare and Medicaid, which funds most of the hospital budget. Once the government legislated what it would cover, hospitals saw a cost/profit crunch, and had to scramble to find the money for already skyrocketing health care prices. Thus emerged more ambulatory and specialty clinics, which boomed from 1990 to 2002, going from 310 to 4000. Prospective reimbursement for Medicare and Medicaid emerged in the form of DRGs (TEFRA 1982). Health systems (HMOs) were also under pressure to contain costs and moved into "managed care." Personnel cutbacks, both medical and administrative, have attempted to reduce overhead hospital costs. Shorter hospital stays have been implemented whenever possible, and the number of outpatient visits has increased, making in-hospital stays less common.

How The Changes Have Addressed Rising Costs

The attempts to contain costs have profoundly affected every type of hospital and healthcare delivery system. One answer has been the consolidation of hospitals (and those employed within) to form multi-hospital systems. This consolidation is an attempt to reshape and in fact provide a foundation for relationships among providers, health plan administrators, institutions (including medical/nursing schools), and the patient/family population they serve. The military is doing this as well. They have formed purchasing regions for medical equipment, drugs, and supplies. Partnerships between medical treatment facilities (MTF's) and Veteran's Administration (VA) hospitals have consolidated health care assets and services. All of these changes signify an effort to provide the customer with what they want at a price that doesn't bankrupt the individual or the government.

With regards to the pharmaceutical companies, health plans have attempted to contain cost by various measures: negotiating lower drug prices, encouraging more cost-conscious physician prescribing patterns, and encouraging use of lower cost therapeutic alternatives (encouraging wider use of generics and discounted preferred-brand drugs). Plans have had limited success particularly in their attempts to change prescribing behavior. As a result we have seen expanded number of drugs requiring prior authorization, increased focus on educating high-cost physicians (such as conducting in-person pharmacist consultations with physicians and sending them letters when high-cost drugs are prescribed), and introducing/expanding disease management instruction to improve delivery and health outcomes for high-cost and high risk populations.

Staffing issues have included a solution to "right-size," thereby cutting down the number of higher-paid staff members required to do certain jobs. Licensed practical nurses or even nursing assistants have replaced registered nurses; more physician assistants have been brought in; more part-time positions have helped reduce overhead costs. This cost-saving measure has been looked upon with disfavor; some feel it impacts negatively on quality of care.

Health insurance is a double-edged sword. People want quality at a low price; they expect to be taken care of and they also want to be included in the process (i.e., knowing what they're purchasing). Did we not relinquish some control when we handed over payment by these sources? At least when there was fee-for-service you knew that you got what you paid for, or so it seemed. It seems like we missed a step in our evolution, in favor of a politically motivated Band-Aid that would solve everything. What ever happened to "insurance" being just good preventive medicine & public health, and that to ensure American's a healthy life, American's should live healthfully? The idea that you defer the cost of an unknown by paying in advance has merit if you know what you are paying for. The complexities of the insurance business as well as the complexities of health care services have made it difficult for many to understand what they are paying for. Yet expectations for outstanding (read: expensive) health care remain. More and more insurance agencies acknowledge that the patient will have to pay the higher premiums to maintain the expectation.

The Future

As a way to meet cost and health care concerns, a continuum of care has been proposed, in the form of Vertical Integration (VI). This seems to be the next evolutionary step. VI is working to provide a full range of cradle to grave services with respect to the target population's needs. Services include:

1. Integrated strategic planning, resource allocation and assessment of system performance
2. Broad range of facilities/services - illness prevention and health promotion, primary care, specialty care, acute care long-term care, home care - all under a single umbrella
3. Network of primary care providers
4. Specialists
5. Mechanisms for coordinating/integrating care
6. Information systems that speak to one another
7. Unified marketing and contracting
8. Integration of financing and delivery through relationships with health care plans

Whereas this may look good on paper, the real proof will be in the results. Initially vertical integration may not bring down costs, as premiums are still on the rise. In the long term, however, those covered may feel that they are getting what they are paying for in coordinated health care and illness management along with decreased hassles while moving through the system. As America grays, the complement and range of services needed are changing. A larger number of the "working" force will be, and in fact are already, caring for elderly family members. We will be in greater need for not only long term care facilities, but also alternatives such as day care for seniors. In the multi-system vertical integration, someone is in the driver's seat looking ahead to the anticipated needs. These VI systems show promise in not only containing costs, but also improving access and quality of healthcare.

In summary, a partnership between patients and the health care system, if it's not already in place, is going to become a larger part of the future. Patients will be asked to contribute more money to pick up the slack. It seems unlikely people will take responsibility for their own wellness unless they have to pay to do so. Further, a "continuum of care" will always be a challenge due to the fluid nature of our healthcare system. Whenever some part of the system changes, that change creates a ripple effect that will influence other parts. If we do get to a point where there is an overall plan or flow to our health care system, we can get to a much truer "continuum" of care, where there is partnering between patient/family and provider, individuals and communities, and health care systems and insurers. At this level, the real push for staying healthy will be realized. Although this may not be "just around the corner," it is a vision worth striving for.